ANNUAL REPORT

public health nursing

"Nebraska was recognized by the federal Health Care Financing Administration for being number two in the nation for enrolling previously uninsured children into Kids Connection."

Governor
Mike Johanns

ACCESS MEDICAID ENROLLMENT AND EDUCATION SERVICES

Access Medicaid is a family/client and physician-centered service delivery system using technology and public health principles to foster improved health outcomes through access, assisting clients in obtaining and maintaining a medical home, coordination of care, case management services, outreach activities and community activities.

During the second year of operation, Access Medicaid has continued to show success in achieving its ongoing goals of improved access, client advocacy, coordination of care and outreach through the Nebraska Health Connection/Kids Connection, the

Reaching for a healthy future

Kids Connection

Nebraska Children's Health Insurance Program

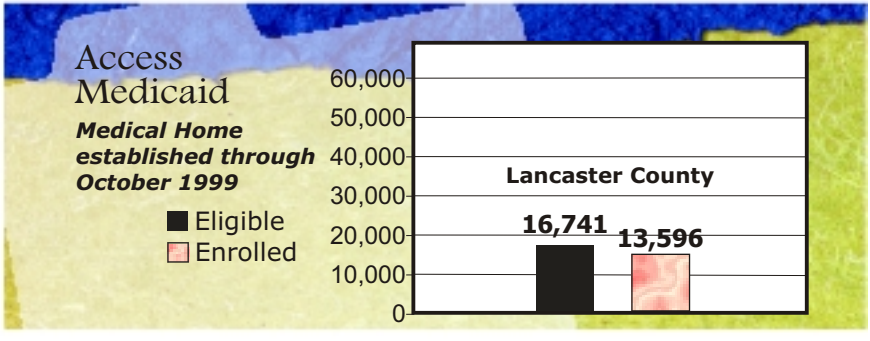
Outreach for clients has expanded to assist refugee, disabled, homeless and teen populations. Staff use interpretation services for clients in need of translation.

Reviewing and refining the extensive outreach plan with client resource specialists and community agency partnerships has helped continue to improve client response rate to 75 percent or greater. The success means clients/families are continuing to actively engage in the education and enrollment process. This process is activated by a Public Health Nurse who incorporates health assessment, case management, advocacy, risk identification, education and care coordination in conjunction with the selection of a doctor and health care plan.

Clients with barrier issues, such as lack of transportation or telephone, can attend a community event or outreach activity in their neighborhoods. Clients may also walk in to the Access Medicaid Office for assistance.

The Public Health Nursing staff has been successful in assisting clients in obtaining medical care, specifically focusing on pregnant women who have had late entry into prenatal care.

To assist in the facilitation of the client/family and physician partnership, a Provider Specialist from the Lancaster County Medical Society meets with physicians and their office staffs to identify barriers to care and potential solutions and problem solving. This component of the program provides an essential link to support physicians in service delivery to clients.



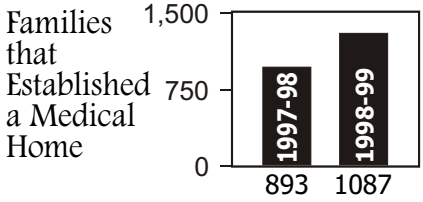
INFORMATION AND REFERRAL

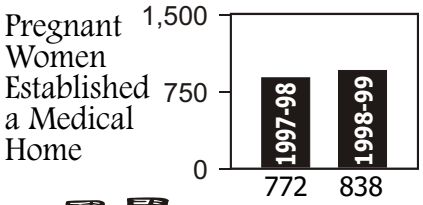
More than 23,000 phone calls were received in I and R this past year. Nurses responded to requests for medical information, triaged calls, assisted callers in making medical appointments and referred others to appropriate resources within the department and community.

The Presumptive Eligibility Program was expanded to assist children needing medical services through the Kids Connection program. Over 360 children were approved for Kids Connection at LLCHD this year. Children with acute health care needs received a nursing assessment and assistance with the establishment of a medical home if one did not exist. Parents were educated regarding the Kids Connection Program and medical home concept. Previous barriers to care, such as lack of transportation or financial help to purchase prescriptions, have been eliminated, thanks to this innovative new program.

One example of the impact of Kids Connection involved a mother who brought her infant to LLCHD seeking help for her sick child. Through the Kids Connection presumptive eligibility process, the child received a temporary medicaid card, was able to see a physician and purchased needed prescriptions for an acute respiratory condition all in one day.

About 840 low income, pregnant women received Presumptive Eligibility services for Medicaid and accessed a permanent medical home and services to enhance positive pregnancy outcomes. More than 7,000 medical transportation requests were processed while fielding 7,698 calls related to medical care access.





Public Health Nursing

home and community services

"A primary goal of the home and community services program is to assure that prenatal care will be accessible to all and well coordinated among health, social and human service providers. Home visitation and case management services will be available to women and children at greatest risk." Carole Douglas, Chief of Public Health Nursing

There were 1,066 new referrals to the Maternal Child Health (MCH) Program. Sources for referrals include physicians, Nebraska Health Connection,

Women Infant Children (nutrition program), Lincoln Public Schools and Access for Prenatal Care.

Home visitation services were provided to about 850 high risk, pregnant women to promote early and regular health care habits. The Public Health Nurse visits as needed up to six months of gestation, then monthly or more frequently during the third trimester. Public Health Nurses visit through postpartum and infancy.

About 30 percent of new program referrals were from ethnic minority families and 70 percent of the pregnant women of ethnic minority accessed prenatal care in the first trimester. Since 1998, 73 percent of all pregnant women enrolled in the project received prenatal care in the first trimester.

The number of new infants provided services through the MCH Project was 567. The total number of visits among infants provided services through the MCH project was 2,559.

Case management, education of prenatal and infant health care needs, and infant care assistance with parental skill development are all incorporated into a Home Visit to ensure positive outcomes for families.

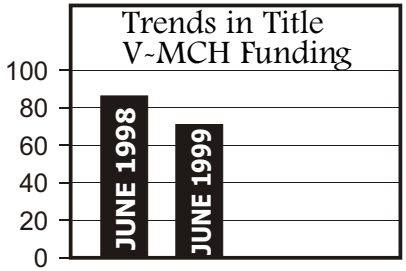
About 21 percent of teen mothers in Lancaster County experience a second pregnancy in

their teen years. However, this rate drops to seven percent for those teen moms in the follow up program.

A funding cut in the MCH grant has resulted in the termination of the tracking portion of the High Risk Infant Program. There is no longer an automatic trigger for a Public Health Nurse referral to follow up on a child at risk who had missed a well child exam. It is anticipated that without the lapse of care follow up, immunization rates will be negatively impacted.

One of the successes from Home and Community Based Services involved a 16-month-old, underweight, malnourished child who had never seen a health care provider. He had little solid food and was primarily breast fed. After intervention with a Public Health Nurse, the child now is gaining weight, and his hemoglobin has returned to the normal range.

A 19-year-old African American woman visited by a Public



Health Nurse in the second trimester of her pregnancy is another success story. She had some complications at 34-week gestation and delivered a healthy infant at 37-38 weeks gestation. At one week postpartum, she was having signs and symptoms of possible postpartum depression. The client later noted that she had made arrangements for the infant's care and for her own funeral. Following education by the Public Health Nurse regarding depression, the family assisted her in initiating mental health care. With support and guidance from the Public Health Nurse, the client's family was able to successfully advocate for her. She was eventually admitted to a program appropriate for addressing her long term needs.

EARLY INTERVENTION SERVICES COORDINATION

Objective: All children up to age three will be referred for services when there is a concern about the child's development.

Outcome:

Total Number of Referrals to the Early Intervention Services Coordination Program					
95-96	96-97	97-98	98-99	1995-99 Increase	% of Increase
246	297	302	329	83	34%

During this past year, one of the families served by the early intervention staff had school-aged twins with cerebral palsy who needed summer care and before and after-school care. Their provider decided to close and gave the family two weeks notice. Through assistance from LLCHD, the family found a provider willing to take the children but anxious about their needs. Consultation was provided to the new provider, and the children were able to transition into their new care smoothly.

Objective: Children who have disabilities or development delays will be referred to services as early as possible.

Children Referred to the Early Intervention Program

AGE	1995-96	1998-99	INCREASE
*Less than 1 year	49	105	115%
*1-2 years	54	72	34%
2-3 years	104	110	stable

*Note: These are two age groups targeted for early referral

QUALITY IMPROVEMENT:

Objective: All Public Health Nursing Division programs and staff will participate in the Division Quality Improvement Program (QIP).

Indicators:

- During the 1998-99 year, a Quality Improvement Coordinator was hired for the division.
- Draft policies and procedures are being developed to establish and implement a division-wide QIP.
- Another example of how the early intervention staff assisted a family involved a child with multiple disabilities who needed respite, in-home nursing, medical equipment, educational services and coordinated medical care. An LLCHD Services Coordinator helped the parents establish in-home providers, a communication notebook and an interagency plan of care that met the needs of both the child and family.

EARLY CARE AND EDUCATION FOR CHILDREN WITH DISABILITIES

Objective: To increase the availability of quality, affordable, licensed child care for children with special needs.

Indicators:

- Twenty-one child care centers and 18 home providers are participating in grant activities to better serve children with special needs. This represents about five percent of licensed providers in Lincoln.
- The participating 18 home providers, licensed to serve a total of 142 children, served 31 children with special needs (22 percent) during the 98-99 grant year.
- The 21 participating centers, licensed to serve a total of 1,648 children, served 135 children with special need (eight percent) during the 1998-99 grant year.

The goal of the WIC program is to make services available to women and children who are at greater risk due to poor health and nutrition. WIC results in access to an array of health and nutrition

services through education and referrals while providing nutritious foods to families in need. WIC has also developed a breastfeeding promotion and support program

for pregnant and postpartum women.

WIC has been able to recover from the caseload losses brought about by the waiting list. Increased funding has allowed for additional staffing as well as the implementation of a quality improvement plan. WIC also headed the SmokeFree Program, which provides smoking cessation to prenatal clients as well as other household members. WIC was able to team with other programs within LLCHD to promote a united smoking cessation message. WIC has also increased community integration through LMEF (Lincoln Medical Education Foundation) Young Families Program and the use of NEP (Nutrition Education Program) staff to enhance nutrition education to clients using both services.

WIC staff consistently see over 820 women and 1,620 infants and children on a monthly basis. WIC at LLCHD continues to serve the highest percentage of pregnant women and infants in the state as well as the largest proportion of high-risk clients (67 percent), which supports the WIC Program's goal of providing easy access to varying health programs. Racial and ethnic minorities continue to comprise 35 percent of the general population.

WIC strives to provide breastfeeding education to pregnant women and their support systems and has an initiation rate of 56 percent, which is higher than the national average of 47 percent. The development of a departmental breastfeeding promotion initiative will help increase the number of contacts in which breastfeeding education will be given.

SCHOOL HEALTH NURSING PROGRAM

A total of 315 school visits to 42 parochial, rural and private schools were done. Over 170 telephone calls were triaged, and 88 parent and teacher conferences were held.

Seven educational inservices were given to 134 people from 35

different schools. Topics included state laws, physicals, screening (dental, hearing, vision, scoliosis, height and weight), eating disorders, immunizations, communicable disease control, first aid, eating disorders, medications in schools, environmental issues, attention deficit syndrome, special needs children and LLCHD services.

A School Health Committee, including representation from the Environmental Health, Health Promotion and Outreach, Public Health Nursing, Dental and Animal Control divisions was formed during this past year. This committee focuses on coordinating services to schools throughout the county and improving communication to schools regarding available resources.

Lancaster County's first Bike/Walk to School Day was held as a collaborative effort with the American Heart Association, State PTO, State of Nebraska Physical Fitness Program, Lancaster County Bike Association, UNL and LLCHD. About 10,000 students participated. This project was presented at the State of Nebraska Initiatives Program and the Governor's Council on Physical Fitness. Next school year's "Walk Your Child to School Day" will be a statewide effort.

LLCHD collaborated with the Lancaster County Head Lice Task Force to address concerns and develop a community plan to address this issue.

The Health Department collaborated with UNMC College of Nursing, Nebraska Wesleyan University and Union College to facilitate teaching and learning opportunities. Student nurses were involved in aggregate studies and teaching projects to address student and community concerns.

CHILD HEALTH CLINIC

This year staff members have spent many hours enrolling children into Kids Connection, Nebraska's Health Insurance Program. Families are given the opportunity to sign up their kids for this insurance program at the time of their Child Health Clinic appointment. As a result of these efforts, many children now have medical homes. When there is an immediate medical need, families without a physician no longer need to take their children to the emergency room. Every day, there are opportunities to enroll children into the Kids Connection

Program through the clinic. These children are assessed by a nurse, and the child is assigned to a primary care physician right away.

PRIMARY CARE CLINIC

This year, 2,386 clients were served by the Primary Care Health Team. Public Health Nurses have worked closely with our physicians, NHHSS staff and specialists in the community to secure health care for citizens of Lancaster County.

Public Health Nurses negotiated care/service for a 35-year-old client who came into the Primary Care Clinic with a fractured leg after being referred to an orthopedic specialist through the emergency room. The client had no job, insurance or other means to pay for the services, so refused to see the specialist. The nurse case manager was able to work with the specialist's office to get the care that the client needed.

Obtaining pharmacy services has been one of the difficulties faced in the Primary Care Clinic. Many clients have low incomes and little or no insurance. Often times, medications are ordered, and it becomes difficult for those who do not qualify for assistance to find the funds for the prescriptions. They must go without the medication or wait until they have enough money to purchase it.

CHRONIC DISEASE

Public Health Nurses work to reduce premature death, disability and economic costs to society due to chronic diseases, especially cardiovascular disease, cancer and diabetes in the frail elderly and persons without health resources.

About 1,800 home visits were provided to 377 persons over age 64. Services are provided under medical direction and include assessment, health education, monitoring of health status and case management to promote client independence and safety in the home setting. About 460 home visits were provided to 168 persons aged 45 through 64 to enhance medical compliance to promote healthy outcomes.

About 1,445 health screening and educational sessions were provided at health stations located throughout the city and county to persons over age 45. These services focus on early detection of disease, management of identified disease and health education.

COMMUNICABLE DISEASE

The Communicable Disease Program is actively involved in disease surveillance throughout the year. In addition, the program does weekly monitoring of school illness reports and influenza monitoring of physician offices during the flu season to be able to alert the public and health care providers when increased disease activity begins to occur.

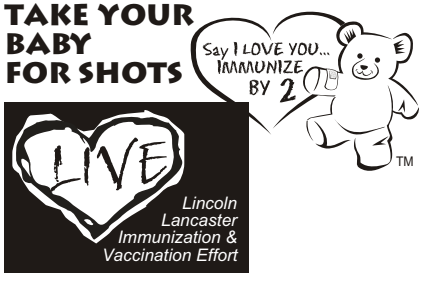
This past year, 7,400 influenza immunizations were provided to those at high risk by the department.

During this past year, the department was actively involved in tracking, follow-up and prevention activities connected to disease outbreaks, including E.coli and Rubella.

The department's Hepatitis B Perinatal Program experienced a significant reduction in grant funding this past year. Although the program was able to continue to work with Hepatitis B infected pregnant females and their newborns, the program had to discontinue its outreach efforts to high-risk individuals.

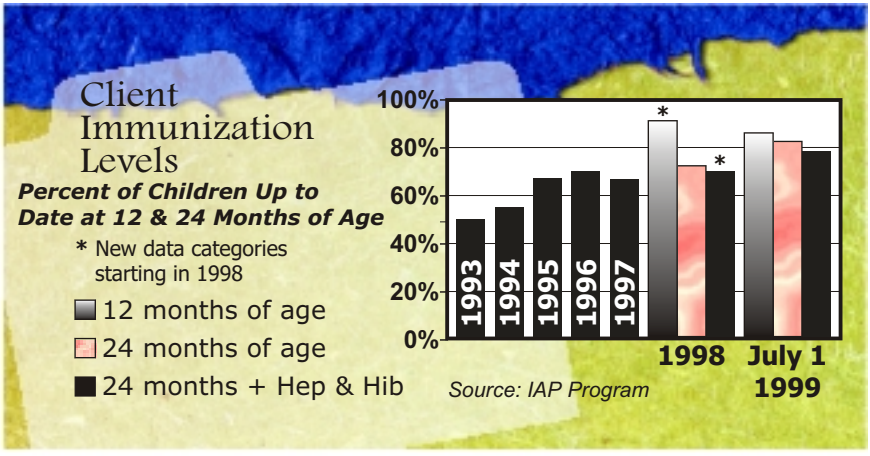
Tuberculosis, a low incidence disease in Lincoln and Lancaster County, is nevertheless monitored, and follow-up is done on all potential or suspect cases and contacts of known cases in our community. The program has seen an increase in utilization of the department's TB clinic by potentially TB infected individuals. The use of "direct observation therapy" (DOT) for those being treated for TB has increased in the past year. Six individuals were on DOT at some time during the past year.

A total of 25,627 immunizations were provided to school age children this past year by department staff. This reflects an increase of about 3,700



immunizations from the previous year. As the number of immunizations provided increased, the department's Immunization Action Program grant received a 29 percent reduction in funding this past year. This necessitated a reduction in immunization clinic hours.

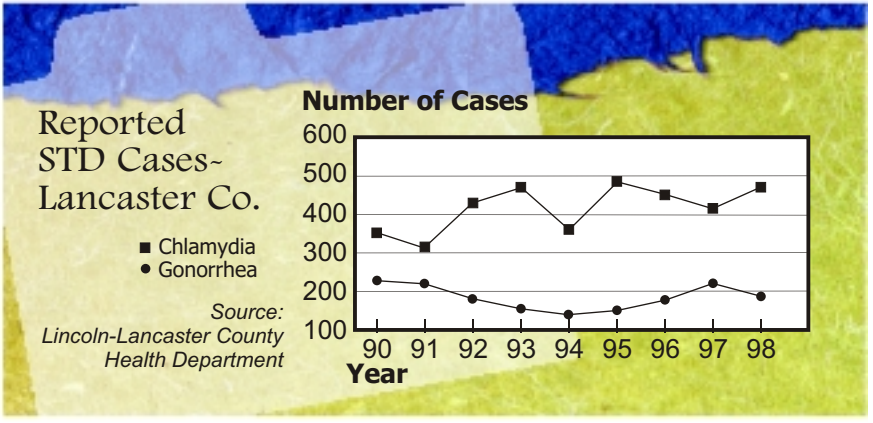
The Communicable Disease program received 1,294 disease reports last year and did 377 epidemiologic follow-up investigations.



There were 94 cases of gonorrhea and chlamydia in Lancaster County in 1998, which is 220 cases per 100,000 population. Gonorrhea incidence was down from 111 cases per 100,000 population in 1997. Chlamydia was up from 196 cases per 100,000 population in 1997.

The incidence of AIDS in Lancaster County is 3.4 cases per 100,000 population. A decline in the number of new AIDS cases this past year, from 12 to eight, reflects the impact new therapies for treating HIV are having on reducing the incidence of AIDS and AIDS deaths.

As concerns regarding the threat of bioterrorism increase, the Communicable Disease Program staff has attended training on bioterrorism and has worked with other areas in the department to develop plans to deal with bioterrorism should an incident occur in our community.



GRANTS AND AWARDS

Nebraska Health and Human Services System

1.	HIV/STD	$ 91,060
2.	Diabetes Education	$ 5,000
3.	Early Intervention Innovative Project	$ 15,000
4.	Early Intervention Service Coordination	$ 325,000
5.	Developmental Disabilities	$ 12,000
6.	Hepatitis B	$ 13,688
7.	High Risk Maternal/Infant Follow-up Program	$ 70,000
8.	NE Immunization Action Plan	$ 61,969
9.	Medical Access Coordination	$ 100,718
10.	Tuberculosis Management	$ 23,700
11.	Women, Infants and Children (WIC)	$ 314,484
12.	Access Medicaid/Health Connection	$2,086,450

Lancaster County

1.	General Assistance	$ 141,500
2.	Jennie B Harrell Attention Center	$ 49,300